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Translation of the Quality of Life for Eating Disorders questionnaire into Hindi

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ABSTRACT

Objective: The Quality of Life for Eating Disorders questionnaire was translated into Hindi (QOL ED-H) using the forward-backward translation procedure for use with Indian females.
Method: A total of ninety-five females were recruited from two secondary schools and one tertiary college from Delhi, India. They were aged between 14 and 37 years, ranging from low to high socioeconomic status communities. A psychologist and teacher produced a preliminary Hindi version, which was back-translated by the psychologist and a journalist and any disparity was checked. The Hindi and English versions were administered one week apart to the same participants, the order being randomised.
Results: Repeated measures analysis revealed no significant differences in QOL ED scores (global and subscores) between the Hindi and English versions, when controlled for age.
Conclusion: The QOL ED-H can be used to assess eating and exercise disordered thinking, feeling, behaviours, psychological feelings and daily living in Indian females of all SES groups.

1. Introduction

There is an increasing number of diagnosed eating disorder cases and more prevalent eating disorder symptomology among Asian female adolescents than in previous times (Lee, 1996). The Indian culture has held a stereotype that being 'fat' or 'full-bodied' signifies wealth, health and happiness. This may have been true in past generations and probably remains in smaller communities, however, urban communities in India have started to aspire to new body ideals and the concept of 'slim is beautiful' (Gandhi, Appaya, & Machado, 1991).

The inventories used to assess eating attitudes and behaviours have been under scrutiny when conducting research within Asian populations. Immigrants and people from the Asian continent, whose first language is not English, may have difficulty understanding eating disorder concepts. This was more evident with people from rural rather than urban communities as they scored higher on the EAT, implying more eating disorder attitudes, however this result is not supported by any past research, nor is there a rational explanation for this difference (Sjostedt, Schumaker, & Nathawat, 1998). This finding could be due to the inaccurate interpretation of the questions and lower levels of English proficiency rather than actual differences in eating attitudes, hence questioning whether the EAT is suitable for use in lower SES groups. Additionally, the scoring of tests is usually based on western norms, which may skew the interpretation of data (King & Bhugra, 1989). Nevertheless, EAT remains the most widely used inventory in most Asian studies.

Inventories may not reflect eating disorder symptomology that are typically present among people in Asian countries (Makino, Tsuboi, & Dennerstein, 2004). Research suggests different diagnostic criteria should be used for Indian girls, rather than the western population, as "fear of fatness" is not evident in Indian girls (Sjostedt et al., 1998; Tareen, Hodes, & Rangel, 2005).

Quality of life measures have become more popular with eating disorder research as we see the importance of evaluating well being and functioning in specific domains of life that may be affected by disordered eating or eating disorders (Engel, Adair, Las Hayas, & Abraham, 2009). Such studies have found that quality of life is poor with the presentation of eating disorder symptomology and changes in quality of life may be used to determine treatment effectiveness. Inventories such as EAT are useful to determine disordered eating attitudes and behaviours however quality of life measures determine the person's own perception of their well being and daily functioning. There has not been a disease specific assessment available for the quality of life related to eating and exercise in the Hindi language, except for QOL ED-H. This questionnaire has been shown to correlate well, and over time, with other recognised eating disorder measures, such as, EAT and EDE (Abraham, Brown, Boyd, Luscombe, & Russell, 2006).

The aim of this study is to translate the Quality of Life: Eating Disorders in Hindi (QOL ED-H) for use within the Hindi speaking population and to ascertain whether the questionnaire is suitable for specific socioeconomic groups.

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2. Methods

2.1. Participants

A total sample consisting of 95 females, of which 7 were secondary co-educational private school students from middle to high SES (school A), 69 were secondary co-educational school from low to middle SES (school B) and 19 were tertiary co-educational college students mostly from low to middle SES (college). Participants were selected randomly and were recruited from classes that were available to us at the time of data collection. There was no bias in the classes that were made available. All schools were located in Delhi, India. Three participants from the schools refused or did not complete the questionnaire. One participant from the college was unable to complete either version of the questionnaire as her literacy levels were not adequate.

We were unable to find a social class classification in this part of India, so we relied on our own judgement and information acquired from the school and college principals to ascertain SES group of each educational institution. School A is located in South Delhi, which is a well-established and more affluent area. Many middle to high class families reside in that part of Delhi. It is a private school, which means students pay fees for enrolment, and English is a more widely accepted medium of communication. School B is located in North Delhi, which is considered to be middle SES. It is also a fee-paying school, however the amount is much lower compared to School A. The college is located in West Delhi, which is generally a low to middle SES area. Many of the students of this college had moved from rural villages located just outside of Delhi as this college is the only one in this part of India to specialise in further physical education. Hindi is the more predominant language used to communicate in this institution. A representative of this college stated that students which elect to partake in a career involving physical education usually belong to low to middle class families.

Students were told that the information was confidential and they could withdraw from the study at any time. Demographic details were also self-reported on a questionnaire. Heights and weights were measured. Participants were not screened for medical, psychological and psychiatric problems, including eating disorders. Ethics approval was granted from the Human Research Ethics Committee at the University of Sydney.

2.2. Measures and procedure

The QOL ED (Abraham, 2008; Abraham et al., 2006) is a section of the Eating and Exercise Examination (EEE), which was developed as an efficient, computer generated and self-reported examination of eating and exercise behaviour, attitudes and feelings. The QOL ED contains 31 items including subscores of Body Weight (BW), Eating Behaviour (EB), Eating Disorder (ED), Psychological (PSY), Acute Medical (AM) and Daily Living (DL), which in turn add up to form the global QOL score. The description of these subscores, means and confidence intervals of an Australian norm sample of females aged between 15 and 35 years are shown in Table 1.

Due to the lack of computer facilities at these institutions, the questionnaire was administered using paper and pen. The QOL ED has been shown to correlate well with other recognised measures of eating disorders, psychological dysfunction, general quality of life and behaviour and body weight, for example Eating Attitude Test and Beck Depression Inventory (Abraham, 2008). It also showed high reliability, internal consistency and was found to be appropriate for retesting over both short and long periods of time with community and eating disorder populations including adolescents.

All questions enquired about the previous 28 days and scored on a scale of 0 = 0 days/not at all, 1 = 1-7 days/a little, 2 = 8-14 days/somewhat, 3 = 15-21 days/moderately, 4 = present 22-28 days/a lot. A score of >1 is considered significant for all measures unless specified.

A teacher and a psychologist (ML), fluent in English and Hindi, carried out the initial translation from English into Hindi. Psychologist (ML) and a journalist/writer in a well-established marketing firm, also fluent in English and Hindi, carried out the back-translation. Minimal changes were made to bring about agreement between both back-translations. Some phrases in English did not result in exactly the same meaning in Hindi, such as “burn energy”, which was then changed to “use up energy”. The bilingual first author (ML) was present during data collection in India to answer any questions.

Participants completed both the English and Hindi versions of the QOL ED with one week interval between each testing. The order was randomised to eliminate learning effect. Questionnaires were completed in school hours in classrooms.

Questions were asked to enquire about participant’s experience of completing the questionnaires, including reported ease of completion for each version of the questionnaire and number of queries that were raised about specific questions. Time to administer the questionnaires was noted after each session.

2.3. Data analysis

All data were analysed using SPSS Version 16 for Windows. Descriptive data were reported, including mean and standard deviation. Repeated measures analysis was used to compare both versions of the questionnaire. Age was a covariate, language (English and Hindi) was allocated as a within-subject variable, QOL subscores and global score were allocated as measures and groups (schools and college) were allocated as a between-subject factor.

3. Results

3.1. Subjects

The mean ages (and SD) of the girls from school A, school B and the college were 14.71 (1.25), 14.94 (1.04) and 21.84 (4.23) years, respectively. The mean body mass index, or BMI, (and SD) for school

Table 1
Brief description of QOL ED scores and mean (and 95% confidence interval) of scores based on western community sample aged 15 to 35 years.

Score	Description	Mean (and 95% CI)
Body Weight (BW)	Based on BMI categories.	0.4 (0.3-0.5)
Eating Behaviour (EB)	Presence of overeating and the weight controlling behaviours of restriction, purging (self-induced vomiting and laxative use) and exercise	1.2 (1.1-1.3)
Eating Disorder (ED)	Feelings related to preoccupation and control of food, eating or body	1.1 (1.0-1.2)
Psychological (PSY)	General psychological questions around emotions, social unease, difficulty coping, needing things to be perfect, fear of loss of control over feelings	1.2 (1.1-1.3)
Acute Medical (AM)	Negative affect of eating and exercise on current medical health	0.3 (0.2-0.4)
Daily Living (DL)	Negative affect of eating, exercise and body on career, social life and relationships	0.8 (0.6-0.9)
Global QOL	Overall QOL as determined by the sum of the above 6 subscores	5.0 (4.6-5.4)